Clear Form

GRAYHAWK
EYE CENTER, PLLC.

Date _____

Name _____
First Middle Last

Address _____
Street Apt # City State Zip

Home Phone # _____ Work Phone # _____
Cell Phone # _____ Social Security # _____
Date of Birth ___/___/___ Email Address _____
Month Day Year
May we contact you? ☐ Yes ☐ No

Check one: Male ☐ Female ☐ Check one: Single ☐ Married ☐ Divorced ☐ Widowed ☐

Employer _____
Address _____ Phone # _____

GUARDIAN/SPOUSE INFORMATION:

Name _____
First Middle Last

Address _____
(If Different From Above) Street Apt # City State Zip

Home Phone # _____ Work Phone # _____
Cell Phone # _____

EMERGENCY CONTACT INFORMATION: (Other than spouse/not living at same address)

Name _____
First Middle Last

Home Phone # _____ Work Phone # _____

How did you hear about us? _____
In a brief statement, tell us the reason for your visit today. _____
Please list eye medication(s) and dosage(s) taken on a regular basis. _____

Please list all prescription medication(s) and dosage(s) taken on a regular basis. _____

How old is your current prescription for contact lenses, glasses? _____

PRIMARY CARE PHYSICIAN

Name _____ Phone # _____

OPTOMETRIST

Name _____ Phone # _____

FAMILY HISTORY: In your family history, do any of the following apply? If so, who?

☐ Cataracts _____ ☐ Glaucoma _____

☐ Diabetes _____ ☐ Other eye disorders/diseases _____

Do you have any of the following problems? (Please check those that pertain to you.)

☐ Diabetes	☐ Heart Problems	☐ Sinus	☐ Seizures
☐ High Blood Pressure	☐ Kidney Problems	☐ Dentures	☐ Shortness of Breath
☐ Chronic Bronchitis	☐ Hearing Impaired	☐ Dizziness	☐ Chest Pain
☐ Tuberculosis	☐ Asthma	☐ Smoker	☐ Hepatitis
☐ High Cholesterol	☐ Bleeding Disorder	☐ Bladder Problems	☐ Other (use line below)

Allergic to any medications? ☐ Yes ☐ No If Yes _____

To the best of your knowledge do you have HIV, Aids, or Aids-Related Complex? ☐ Yes ☐ No

To the best of your knowledge are you pregnant? ☐ Yes ☐ No

Previous Surgeries in your lifetime (include childhood): _____

☐ Tonsillectomy ☐ Appendectomy ☐ Hysterectomy ☐ Prostate ☐ Gall Bladder

INSURANCE INFORMATION:

Primary Insurance Company _____ Policy # _____ Group # _____

Policyholder's Name _____ SS# & DOB _____

Secondary Insurance Company _____ Policy # _____ Group # _____

Policyholder's Name _____ SS# & DOB _____

PATIENT'S RIGHTS AND RESPONSIBILITIES:

1. Release of information:
   I hereby give consent to Grayhawk Eye Center, PLLC., and Associates to release any information regarding my care and treatment as may be required by any insurance carrier for any portions of my bill.
2. Responsibilities for payment/patient agreement:
   I understand that the doctors at Grayhawk Eye Center, PLLC., and Associates are not responsible for deductibles made by any insurance company, government agency, HMO/PPO plans, etc. I agree to pay any portion of fees charged by Grayhawk Eye Center, PLLC., and Associates for services rendered to me that are not covered by my insurance company.
3. Assignments of benefits:
   I authorize my insurance company to assign benefits to Grayhawk Eye Center, PLLC., and Associates

I have read and understand the above

_____

Patient or Guarantor Signature Date

Print Form Save Form